

## Smiths in Meat Marketing

DR. R. R. GREEN  
375 E. 2ND ST. *No.*  
HEBER CITY, UTAH  
84032

Rutchen

See book of  
Haskell Stone  
Descendants John Collins  
of New Davis  
for all the Smith  
Descendants

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## HEALTH INSURANCE CLAIM FORM

RAILROAD EMPLOYEE

INSURED BY THE TRA

Type or Print

☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☒ OTHER

## PATIENT &amp; INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (first name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)	5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	6. INSURED'S I.D. NO. OR MEDICARE NO. (Include suffixes)
	7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>	8. INSURED'S GROUP NO. (Or Group Name)
9. OTHER HEALTH INSURANCE COVERAGE — ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. AN AUTO ACCIDENT YES <input type="checkbox"/> NO <input type="checkbox"/>	11. INSURED'S ADDRESS (Street, city, state, ZIP code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE <small>I authorize the Release of any Medical Information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below</small>		13. I authorize payment of medical benefits to undersigned physician or supplier for service described below
SIGNED _____ DATE _____		SIGNED (Insured or authorized person) _____

## PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: <input type="checkbox"/> ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____	DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____
19. NAME OF REFERRING PHYSICIAN		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES: _____
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE		

1.  
2.  
3.  
4.

A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE IDENTIFY ( ) (Explain Unusual Services or Circumstances)	D DIAGNOSIS CODE	E CHARGES	F